(b) Each facility's Base Year per diem allowable Director of Nursing costs shall be calculated by dividing the Base Year total allowable Director of Nursing costs by total Base Year resident days.

(c) The Director of Nursing per diem rate shall be the facility's Base Year per diem allowable Director of Nursing costs calculated pursuant to this subsection.

7.6 **Ancillary Services Rate**

(a) There is no common or established practice in the State of Vermont regarding:

(1) items and services considered ancillaries,

(2) charging practices.

(b) All therapy services and therapy supplies shall be considered ancillaries, whether or not the provider customarily records charges for these services and supplies. Therapy services shall not be allowable for Medicaid reimbursement pursuant to this subsection unless the services are provided:

(1) pursuant to a physician's order,

(2) by a licensed therapist or other State certified or registered therapy assistant, or other therapy aides, and

(3) the facility has a denial of payment by the Medicare program for the services provided.

(c) Other items and services shall be considered ancillaries if the following requirements are met:

(1) separate charges are customarily recorded by the provider for all residents using this service;

(2) directly identifiable services are rendered to a specific resident;

(3) items or services are furnished at the direction of a physician because of specific medical needs;

(4) and one of the following:

(i) not reusable - e.g., intravenous fluids or solutions, oxygen (including medications), disposable catheters;

(ii) represents a cost for each preparation, e.g., catheters, colostomy bags, drainage equipment, trays and tubing; or

(iii) complex medical equipment - e.g., ventilators, intermittent positive pressure breathing (IPPB) machines, nebulizers, suction pumps, continuous positive airway pressure (CPAP) devices.

(d) The Ancillary per diem rate shall be computed as follows:

(1) Using each facility's most recently settled annual cost report, Medicaid Ancillary costs shall be determined in accordance with subsection 6.7.

(2) Using each facility's most recently settled cost report, the per diem Ancillary rate shall be calculated by dividing allowable Medicaid Ancillary costs by the number of Medicaid resident days. Any change to the Ancillary per diem rate shall be implemented at the time of the first quarterly case-mix rate recalculation after the cost report is settled.

7.7 **Property and Related Per Diem**

The Property and Related per diem rate shall be computed as follows:

(a) Using each facility's most recently settled annual cost report, total allowable Property and Related costs shall be determined in accordance with Subsection 6.6.

(b) Using each facility's most recently settled cost report, the per diem property and related costs shall be calculated by dividing allowable property and related costs by total resident

days. Any change to the property and related per diem rate shall be implemented at the time of the first quarterly case-mix rate recalculation after the cost report is settled.

8 ADJUSTMENTS TO BASE RATES

8.1 Change in Services

The Division, on application by a provider, may make an adjustment to the prospective case-mix rate for additional costs which are directly related to:

(a) the offering of a new institutional health service previously approved under the provisions of 18 V.S.A. §9434. Costs greater than those approved in the Certificate of Need (as adjusted for inflation) will not be considered when calculating such an adjustment,

(b) a change in services or facility not covered under the provisions of 18 V.S.A. §9434, if such a change has previously been approved by the Division, or

(c) with the prior approval of the Division, a reduction in the number of licensed beds.

8.2 Change in Law

The Division may make or a provider may apply for an adjustment to a facility's prospective case-mix rate for additional costs that are a necessary result of complying with changes in applicable federal and state laws, and regulations, or the orders of a State agency that specifically requires an increase in staff or other expenditures.

8.3 Facilities in Receivership

(a) The Division, on application by a receiver appointed pursuant to state or federal law, may make an adjustment to the prospective case-mix rate of a facility in receivership for the reasonable and necessary additional costs to the facility incurred on account of the receivership.

(b) On the termination of the receivership, the Division shall recalculate the prospective case-mix rate to eliminate this adjustment.

8.4 Efficiency Measures

The Division, on application by a provider, may make an adjustment to a prospective case-mix rate for additional costs which are directly related to the installation of energy conservation devices or the implementation of other efficiency measures, if they have been previously approved by the Division.

8.5 Interest Rates

(a) A provider may apply for an adjustment to the Property and Related rate, or the Division may initiate an adjustment if there are cumulative interest rate increases or decreases of more than one-half of one percentage point because of existing financing agreements with a balloon payment or a refinancing clause that forces a mortgage to be refinanced at a different interest rate, or because of a variable rate of adjustable rate mortgages.

(b) A provider with an interest rate adjustment shall notify the Division of any change in the interest rate within 10 days of its receipt of notice of that change. The Division may rescind all interest rate adjustments of any facility failing to file a timely notification pursuant to this subsection for a period of up to two years.

8.6 Emergencies and Unforeseeable Circumstances

(a) The Division, on application by a provider, may make an adjustment to the prospective case-mix rate under emergencies and unforeseeable circumstances, such as damage from fire or flood.

(b) Providers must carry sufficient insurance to address adequately such circumstances.

8.7 **Procedures and Requirements for Rate Adjustments**

(a) Application for a rate adjustment pursuant to this section should be made as follows. Approval of any application for a rate adjustment under this section is at the sole discretion of the Director.

(b) Except for applications made pursuant to subsection 4.11, no application for a rate adjustment should be made if the change to the rate would be smaller than one percent of the rate in effect at the time.

(c) Application for a Rate Adjustment shall be made on a form prescribed by the Director and filed with the Division and shall be accompanied by all documents and proofs determined necessary for the Division to make a decision.

(d) The burden of proof is at all times on the provider to show that the costs for which the adjustment has been requested are reasonable, necessary and related to resident care.

(e) The Division may grant or deny the Application, or make an adjustment modifying the provider's proposal. If the materials filed by the provider are inadequate to serve as a basis for a reasonable decision, the Division shall deny the Application, unless additional proofs are submitted.

(f) The Division shall not be bound in considering other Applications, or in determining the allowability of reported costs, by any prior decision made on any Application under this section. Such decisions shall have no precedential value either for the applicant facility or for any other facility. Principles and decisions of general applicability shall be issued as a Division practice or procedure, pursuant to Section 1.8(d).

(g) For adjustments requiring prior approval of the Division, such approval should be sought before the provider makes any commitment to expenditures. An Application for Prior Approval is subject to the same requirements as an Application for a Rate Adjustment under this section.

(h) Rate adjustments made under this section may be continued as such, at the discretion of the Division, notwithstanding a general rebase of costs. Costs which are the basis for a continuing rate adjustment shall not be included in the cost categories used as the basis for the other rate components.

(i) The Division may require an applicant for a rate adjustment under this section or under subsection 4.11 to file a budget cost report in support of its application.

(j) When determined to be appropriate by the Division, a budget rate may be set for the facility according to the procedures in and subject to the provisions of subsection 5.9 Appropriate cases may include, but are not limited to, changes in the number of beds, an addition to the facility, or the replacement of existing property.

(k) In calculating an adjustment under this section and subsection 4.11, the Division may take into account the effect of such changes on all the cost categories of the facility.

(l) A revision may be made prospectively to a rate adjustment under this section and subsection 4.11 based on a "look-back" which will be computed based on a provider's actual allowable costs.

(m) In this subsection "additional costs" means the incremental costs of providing resident care directly and proximately caused by one of the events listed in this section or subsection 4.11. Increases in costs resulting from other causes will not be recognized. It is not intended that this section be used to effect a general rebase in a facility's costs.

8.8 **Limitation on Availability of Rate Adjustments**

Providers may not apply for a rate adjustment under this section for the sole reason that actual costs incurred by the facility exceed the rate of payment.

9 PRIVATE NURSING FACILITY AND STATE NURSING FACILITY RATES

The Medicaid per diem payment rate for nursing home services are calculated according to this section as follows:

9.1 Nursing Facility Rate Components

The per diem rate of reimbursement consists of the following rate components:

(a) Nursing Care
(b) Resident Care
(c) Indirect
(d) Director of Nursing
(e) Property and Related
(f) Ancillaries
(g) Adjustments (if any)

9.2 Calculation of the Total Rate

The total per diem rate in effect for any nursing facility shall be the sum of the rates calculated for the components listed in Subsection 9.1, adjusted in accordance with the Inflation Factors, as described in Subsection 5.8.

9.3 Updating Rates for a Change in the Average Case-Mix Score

(a) The Nursing Care rate component shall be updated quarterly, on the first day of January, April, July and October, for changes in the average case-mix score of the facility's Medicaid residents.

(b) The Nursing Care rate component and any part of a Section 8 adjustment that reimburses nursing costs are updated for a change in the average case-mix score for the facility's Medicaid residents. The up-date is calculated as follows:

(1) The Nursing Care rate component (or rate adjustment) in the current rate of reimbursement for a facility is divided by the average case-mix score used to determine the current Nursing Care rate component. This quotient is the current Nursing Care rate per case-mix point.

(2) The current Nursing Care rate component (or rate adjustment) per case-mix point is multiplied by the new average case-mix score. This product is the new Nursing Care rate component (or rate adjustment).

9.4 State Nursing Facilities

State nursing facilities shall be subject to the provisions of these rules, except for the rate limitations in Section 7 and subsection 9.1(g). However, at no time shall the rates paid to State nursing facilities exceed the upper limits established in 42 C.F.R. §447.272(b).

10 EXTRAORDINARY FINANCIAL RELIEF

10.1 Objective

In order to protect Medicaid recipients from the closing of a nursing facility in which they reside, this section establishes a process by which nursing homes that are in immediate danger of failure may seek extraordinary financial relief. This process does not create any entitlement to rates in excess of those required by 33 V.S.A. Chapter 9 or to any other form of relief.

10.2 Nature of the Relief

(a) Based on the individual circumstances of each case, the Director may recommend any of the following on such conditions as she or he shall find appropriate: a rate adjustment, an advance of Medicaid payments, other relief appropriate to the circumstances of the applicant, or no relief.

(b) The Director's Recommendation shall be in writing and shall state the reasons for the Recommendation. The Recommendation shall be a public record.

(c) The Recommendation shall be reviewed by the Secretary who shall make a Final Decision, which shall not be subject to administrative or judicial review.

10.3 **Criteria to be Considered by the Division**

(a) Before a provider may apply for extraordinary financial relief, its financial condition must be such that there is a substantial likelihood that it will be unable to continue in existence in the immediate future.

(b) The following factors will be considered by the Director in making the Recommendation to the Secretary:

(1) the likelihood of the facility's closing without financial assistance,

(2) the inability of the applicant to pay bona fide debts,

(3) the potential availability of funds from related parties, parent corporations, or any other source,

(4) the ability to borrow funds on reasonable terms,

(5) the existence of payments or transfers for less than adequate consideration,

(6) the extent to which the applicant's financial distress is beyond the applicant's control,

(7) the extent to which the applicant can demonstrate that assistance would prevent, not merely postpone the closing of the facility,

(8) the extent to which the applicant's financial distress has been caused by a related party or organization,

(9) the quality of care provided at the facility,

(10) the continuing need for the facility's beds, and

(11) other factors found by the Director to be material to the particular circumstances of the facility.

10.4 **Procedure for Application**

(a) An Application for Extraordinary Financial Relief shall be filed with the Division according to procedures to be prescribed by the Director.

(b)The Application shall be in writing and shall be accompanied by such documentation and proofs as the Director may prescribe. The burden of proof is at all times on the provider. If the materials filed by the provider are inadequate to serve as a basis for a reasoned recommendation, the Division shall deny the Application, unless additional proofs are submitted.

(c) The Secretary shall not be bound in considering other Applications by any prior decision made on any Application under this section. Such decisions shall have no precedential value either for the applicant facility or for any other facility.

11 PAYMENT FOR OUT-OF-STATE PROVIDERS

11.1 **Long-Term Care Facilities Other Than Rehabilitation Centers**

Payment for services, other than Rehabilitation Center services, provided to Vermont Medicaid residents in long-term care facilities in another state shall be at the per diem rate established for Medicaid payment by the appropriate agency in that state. Payment of the per diem rate shall constitute full and final payment, and no retroactive settlements will be made.

11.2 **Rehabilitation Centers**

(a) Payment for prior-authorized Rehabilitation Center services provided in nursing facilities located outside Vermont for the severely disabled, such as head injured or ventilator dependent people, will be made at the lowest of:

(1) the amount charged; or

(2) the Medicaid rate, including ancillaries as paid by at least one other state agency in HCFA Region I.

(b) Payment for Rehabilitation Center services which have not been prior authorized by the Director of the Office of Vermont Health Access or a designee will be made according to Subsection 11.1.

11.3 **Pediatric Care**

No Medicaid payments will be made for services provided to Vermont pediatric residents in out-of-state long-term care facilities with out the prior authorization of the Director of the Office of Vermont Health Access.

12 RATES FOR ICF/MRS

12.1 **Reasonable Cost Reimbursement**

Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) are paid according to Medicaid principles of reimbursement, pursuant to the *Regulations Governing the Operation of Intermediate Care Facilities for the Mentally Retarded* adopted by the Agency for the Department of Developmental and Mental Health Services.

12.2 **Application of these Rules to ICF/MRS**

The Division's Accounting Requirements (Section 2) and Financial Reporting (Section 3) shall apply to this program.

13 RATES FOR SWING BEDS

Payment for swing-bed nursing facility services provided by hospitals, pursuant to 42 U.S.C. §1396l(a), shall be made at a rate equal to the average rate per diem during the previous calendar year under the State Plan to nursing facilities located in the State of Vermont. Supplemental payments made pursuant to section 14 and section 17 shall not be included in the calculation of swing-bed rates.

14 SPECIAL RATES FOR DIFFICULT TO PLACE INDIVIDUALS

14.1 **Availability of Special Rates**

(a) In rare and exceptional circumstances, Vermont nursing facilities may be paid a special rate for the care of an individual eligible for the Vermont Medicaid program whose unique physical conditions makes it otherwise extremely difficult to obtain appropriate long-term care.

(b) A special rate under this section is available at the sole discretion of the Director of the Office of Vermont Health Access subject to the conditions set out below. The decision of the Director of the Office of Vermont Health Access shall not be subject to judicial or administrative review.

14.2 **Required Findings**

Before a rate is payable under this section:

(a) the Director of the Office of Vermont Health Access, in consultation with the Office's Medical Director, and the Director of Licensing and Protection, must make a written finding that the individual's care needs meet the requirements of this section and that the proposed placement is appropriate for that individual's needs; and

(b) the Division of Rate Setting, in consultation with the Director of the Office of Health Access and the Commissioner of Aging and Disabilities must determine that the special rate set under this section is lower than the lowest cost of an appropriate and available care alternative.

14.3 **Plan of Care**

(a) Before an individual can be placed with any facility and a rate established, pursuant to this subsection, a plan of care for that person must be approved by the Director of Licensing and Protection and the Medical Director of the Office of Vermont Health Access.

(b) The facility shall submit the resident's assessment and plan of care for review by the Director of Licensing and Protection and the Medical Director of the Office of Vermont Health Access whenever there is a significant change in the resident's condition, but in no case less frequently than every six months. This review shall form the basis for a determination that the payment of the special rate should be continued or revised pursuant to 14.4(b).

14.4 **Calculation of the Special Rate**

(a) A per diem rate shall be set by the Division based on the budgeted allowable incremental costs for the individual's plan of care. The rate shall be exempt from the limits in section 7 of these rules.

(b) From time to time the special rate may be revised to reflect significant changes in the resident's assessment and care plan.

(c) Special rates set under this section shall not affect the facility's normal per diem rate. The case-mix weight of any resident on whose behalf a special rate is paid shall not be included in the calculation of the facility's average case-mix score pursuant to subsection 7.2(b), but the days of care shall be included in the facility's Medicaid days and total resident days.

15 ADMINISTRATIVE REVIEW AND APPEALS

15.1 **Draft Findings and Decisions**

(a) Before issuing findings on any Desk Review, Audit of a Cost Report, statement of deprecation recapture, or decision on any application for a rate adjustment, the Division shall serve a draft of such findings or decision on the affected provider. If the Division makes no adjustment to a facility's reported costs or application for a rate adjustment, the Division's findings shall be final and shall not be subject to appeal under this section.

(b) The provider shall review the draft upon receipt. If it desires to review the Division's work papers, it shall file, within 10 days, a written Request for Work Papers on a form prescribed by the Director.

15.2 **Request for an Informal Conference on Draft Findings and Decisions**

(a) Within 15 days of receipt of either the draft findings or decision or requested work papers, whichever is the later, a provider that is dissatisfied with the draft findings or decision issued pursuant to Subsection 15.1(a) may file a written Request for an Informal Conference with the Division's staff on a form prescribed by the Director.

(b) Within 10 days of the receipt of the Request, the Division shall contact the provider to arrange a mutually convenient time for the informal conference, which shall be held within 45 days of the receipt of the Request at the Division. The informal conference may be held by telephone. At the conference, if necessary, a date certain shall be fixed by which the provider may file written submissions or other additional necessary information. Within 20 days thereafter, the Division shall issue its official agency action.

(c) A Request for an Informal Conference must be pursued before a Request for Reconsideration can be filed pursuant to Subsection 15.3.

(d) Should no timely Request for an Informal Conference be filed within the time period specified in Subsection 15.2(a), the Division's draft findings and/or decision are final and no longer subject to administrative review or judicial appeal.

15.3 **Request for Reconsideration**

(a) A provider that is aggrieved by an official action issued pursuant to Subsection 15.2(b) may file a Request for Reconsideration.

(b) A Request for Reconsideration must be pursued before an appeal can be taken pursuant to 33 V.S.A. 909(a).

(c) The Request for Reconsideration must be in writing, on a form prescribed by the Director, and filed within 30 days of the provider's receipt of the official action.

(d) Within 10 days of the filing of a Request for Reconsideration, the provider must file the following:

(1) A request for a hearing, if desired;

(2) a clear statement of the alleged errors in the Division's action and of the remedy requested including: a description of the facts on which the Request is based, a memorandum stating the support for the requested relief in this rule, HCFA-15, or other authority for the requested relief and the rationale for the requested remedy; and

(3) if no hearing is requested, evidence necessary to bear the provider's burden of proof, including, if applicable, a proposed revision of the Division's calculations, with supporting work papers.

(e) Issues not raised in the Request for Reconsideration shall not be raised later in this proceeding or in any subsequent proceeding arising from the same action of the Division, including appeals pursuant to 33 V.S.A. §909.

(f) If a hearing is requested, within 10 days of the receipt of the Request for Reconsideration, the Division shall contact the provider to arrange a mutually agreeable time.

(g) The hearing shall be conducted by the Director or her or his designee. The testimony shall be under oath and shall be recorded either stenographically or on tape. If the provider so requests, the Division staff involved in the official action appealed shall appear and testify. The Director, or her or his designee, may hold the record open to a date certain for the receipt of additional materials.

(h) The Director shall issue a Final Order on Request for Reconsideration no later than 30 days after the record closes. Pending the issuance of a final order, the official action issued pursuant to subsection 15.2(b) shall be used as the basis for setting an interim rate from the first day of the calendar quarter following its issuance. Final orders shall be effective from the effective date of the official action, except for appeals of the calculation of depreciation recovery which shall be effective from the date of the sale and which shall accrue interest from that date at the legal rate.

(i) Proceedings under this section are not subject to the requirements of 3 V.S.A. Chapter 25.

15.4 **Appeals from Final Orders of the Division**

(a) Within 30 days of the date thereof, a nursing facility aggrieved by a Final Order of the Division may file an appeal pursuant to 33 V.S.A. §909(a) and Subsections 15.5, 15.6 and 15.7 of this rule.

(b) Within 30 days of the date thereof, a ICF/MR aggrieved by a Final Order of the Division may file an appeal using the following procedures. Proceedings under this paragraph are not subject to the requirements of 3 V.S.A. Chapter 25.

(1) Request for Administrative Review by the Commissioner of the Department of Developmental and Metal Health Services. The Commissioner or a designee shall review a final order of the Division of Rate Setting if a timely request is filed with the Director of the Division.

(i) Within 10 days of the receipt of the Request, the Director shall forward to the Commissioner a copy of the Request for Administrative Review and the materials that represent the documentary record of the Division's action.

(ii) The Commissioner or the designee shall review the record of the appeal and may request such additional materials as they shall deem appropriate, and shall, if requested by the provider, convene a hearing on no less than 10 days written notice to the provider and the Division. Within 45 days after the close of the re-

cord, the Commissioner or the designee shall issue a decision which shall be served on the provider and the Division.

(2) Appeal to the Secretary of Human Services. Within 20 days of the date of the date of issuance, an ICF/MR aggrieved by the Commissioner's decision, may appeal to the Secretary.

(i) The Notice of Appeal shall be filed with the Commissioner, who, within 10 days of the receipt of the Notice, shall forward to the Secretary a copy of the Notice and the record of the Administrative Review.

(ii) The Secretary or his designee shall review the record of the Administrative Review and may, within their sole discretion, hold a hearing, request more documentary information, or take such other steps to review the Commissioner's decision as shall seem appropriate.

(iii) Within 60 days of the filing of the Notice of Appeal or the closing of the record, whichever is the later, the Secretary or the designee shall issue a Final Determination.

(3) Further review of the Final Determination is available only pursuant to Rule 75 of the Vermont Rules of Civil Procedure.

15.5 **Request for Administrative Review to the Secretary of Human Services pursuant to 33 V.S.A. §909(a)(3)**

(a) No appeal may be taken under this section when the remedy requested is retrospective relief from the operation of a provision of this rule or such other relief as may be outside the power of the Secretary to order. Such relief may be pursued by an appeal to the Vermont Supreme Court or Superior Court pursuant to 33 V.S.A. §909(a)(1) and (2), or prospectively by a request for rulemaking pursuant 3 V.S.A. §806.

(b) Appeals under this section shall be governed by the relevant provisions of the Administrative Procedures Act, 3 V.S.A. §§809-815.

(c) Proceedings under this section shall be initiated by filing two copies of a written Request for Administrative Review with the Division, on forms prescribed therefor.

(d) Within 5 days of receipt of the Request, the Director shall forward one copy to the Secretary. Within 10 days thereafter, the Secretary shall designate an independent appeals officer who shall be a registered or certified public accountant. The Letter of Designation shall be served on all parties to the appeal. All documents filed thereafter shall be filed directly with the independent appeals officer and copies served on all parties.

(e) Within 10 days of the designation of an independent appeals officer, the Division shall forward to him or her those materials that represent the documentary record of the Division's action.

(f) Within 30 days thereafter, the independent appeals officer shall, on reasonable notice to the parties, convene a prehearing conference (which may be held by telephone) to consider such matters as may aid in the efficient disposition of the case, including but not limited to:

(1) the simplification of the issues,

(2) the possibility of obtaining stipulations of fact and/or admissions of documents which will avoid unnecessary proof,

(3) the appropriateness of prefiled testimony,

(4) a schedule for the future conduct of the case.

The independent appeals officer shall make an order which recites the action taken at the conference, including any agreements made by the parties.

(g) The independent appeals officer shall hold a hearing, pursuant to 3 V.S.A. §809, on no less than 10 days written notice to the parties, according to the schedule determined at the prehearing conference. The independent appeals officer shall have the power to subpoena witnesses and documents and administer oaths. Testimony shall be under oath and shall be recorded either stenographically or on tape. Prefiled testimony, if admitted into evidence, shall be included in the transcript, if any, as though given orally at the hearing. Evidentiary matters shall be governed by 3 V.S.A. §810.

(h) The independent appeals officer may allow or require each party to file Proposed Findings of Fact which shall contain a citation to the specific part or parts of the record containing the evidence upon which the proposed finding is based. The Proposed Findings shall be accompanied by a Memorandum of Law which shall address each matter at issue.

(i) Within 60 days after the date of the hearing, or after the filing of Proposed Findings of Fact, whichever is the later, the independent appeals officer shall file with the Secretary a Recommendation for Decision, a copy of which shall be served on each of the parties. The Recommendation for Decision shall include numbered findings of fact and conclusions of law, separately stated, and a proposed order. If a party has submitted Proposed Findings of Fact, the Recommendation for Decision shall include a ruling upon each proposed finding. Each party's Proposed Findings and Memorandum of Law shall accompany the Recommendation.

(j) At the time the independent appeals officer makes her or his Recommendation, she or he shall transmit the docket file to the Secretary. The Secretary shall retain the file for a period of at least one year from the date of the Final Determination in the docket. In the event of an appeal of the Secretary's Final Determination to the Vermont Supreme Court or to Superior Court, the Secretary shall make disposition of the file as required by the applicable rules of civil and appellate procedure.

(k) Any party aggrieved by the Recommendation for Decision may file Exceptions, Briefs, and if desired, a written Request for Oral Argument before the Secretary. These submissions shall be filed with the Secretary within 15 days of the date of the receipt of a copy of the Recommendation and copies served on all other parties.

(l) If oral argument is requested, within 20 days of the receipt of the Request for Oral Argument, the Secretary shall arrange with the parties a mutually convenient time for a hearing.

(m) Within 45 days of the receipt of the Recommendation or the hearing on oral argument, whichever is the later, the Secretary shall issue a Final Determination which shall be served on the parties.

(n) A party aggrieved by a Final Determination of the Secretary may obtain judicial review pursuant to 33 V.S.A. §909(a)(1) and (2) and Subsections 15.6 and 15.7 of this Rule.

15.6 Appeal to Vermont Supreme Court pursuant to 33 V.S.A. §909(a)(1)

Proceedings under this section shall be initiated, pursuant to the Vermont Rules of Appellate Procedure, as follows:

(a) by filing a Notice of Appeal from a Final Order with the Division; or

(b) by filing a Notice of Appeal from a Final Determination with the Secretary.

15.7 Appeal to Superior Court pursuant to 33 V.S.A. §909(a)(2)

De novo review is available in the Superior Court of the county where the nursing facility is located. Such proceedings shall be initiated, pursuant to Rule 74 of the Vermont Rules of Civil Procedure, as follows:

(a) by filing a Notice of Appeal from a Final Order with the Division; or

(b) by filing a Notice of Appeal from a Final Determination with the Secretary.

15.8 **Settlement Agreements**

The Director may agree to settle reviews and appeals taken pursuant to Subsections 15.3 and 15.5, and, with the approval of the Secretary, may agree to settle other appeals taken pursuant to 33 V.S.A. §909 and any other litigation involving the Division on such reasonable terms as she or he may deem appropriate to the circumstances of the case.

16 DEFINITIONS AND TERMS

For the purposes of these rules the following definitions and terms are used:

Accrual Basis of Accounting: an accounting system in which revenues are reported in the period in which they are earned, regardless of when they are collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

Agency: the Agency of Human Services.

AICPA: American Institute of Certified Public Accountants.

Allowable Costs or Expenses: costs or expenses that are recognized as reasonable and related to resident care in accordance with these rules.

Ancillary Services: therapy services and therapy supplies, including oxygen, whether or not separate charges are customarily made. Other medical items or services identifiable to a specific resident furnished at the direction of a physician and for which charges are customarily made in addition to the per diem charge.

Base Year: a calendar year for which the allowable costs are the basis for the case-mix prospective per diem rate.

Case-Mix Weight: a relative evaluation of the nursing resources used in the care of a given class of residents.

Certificate of Need (CON): certificate of approval for a new institutional health service, issued pursuant to 18 V.S.A. §2403.

Certified Rate: the prospective case-mix rate certified by the Division of Rate Setting to the Department of Social Welfare.

Common Control: where an individual or organization has the power to influence or direct the actions or policies of both a provider and an organization or institution serving the provider, or to influence or direct the transactions between a provider and an organization serving the provider. The term includes direct or indirect control, whether or not it is legally enforceable.

Common Ownership: where an individual or organization owns or has equity in both a facility and an institution or organization providing services to the facility.

Cost Finding: the process of segregating direct costs by cost centers and allocating indirect costs to determine the cost of services provided.

Cost Report: a report prepared by a provider on forms prescribed by the Division.

Direct Costs: costs which are directly identifiable with a specific activity, service or product of the program.

Director: the Director of Administrative Services and Rate Setting, Agency of Human Services.

Division: the Division of Rate Setting, Agency of Human Services.

Donated Asset: an asset acquired without making any payment in the form of cash, property or services.

DRI: Standard & Poors' DRI *Health Care Costs*, including national forecasts of hospital, nursing home, and home health agency market baskets and regional forecasts of CPI (All Urban) for food and commercial power and CPIU-All Items.

Facility or nursing facility: a nursing home facility licensed and certified for participation in the Medicaid Program by the State of Vermont.

Fair Market Value: the price an asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition.

FASB: Financial Accounting Standards Board.

Final Order of the Division: an action of the Division which is not subject to change by the Division, for which no review or appeal is available from the Division, or for which the review or appeal period has passed.

Free standing facility: a facility that is not hospital-affiliated.

Funded Depreciation: funds that are restricted by a facility's governing body for purposes of acquiring assets to be used in rendering resident care or servicing long term debt.

Fringe Benefits: shall include payroll taxes, workers' compensation, pension, group health, dental and life insurances, profit sharing, *cafeteria* plans and flexible spending plans, child care for employees, employee parties, and gifts shared by all staff. Fringe benefits may include tuition for college credit in a discipline related to the individual staff member's employment or costs of obtaining a GED.

Generally Accepted Accounting Principles (GAAP): those accounting principles with substantial authoritative support. In order of authority the following documents are considered GAAP: (1) FASB Standards and Interpretations, (2) APB Opinions and Interpretations, (3) CAP Accounting Research Bulletins, (4) AICPA Statements of Position, (5) AICPA Industry Accounting and Auditing Guides, (6) FASB Technical Bulletins, (7) FASB Concepts Statements, (8) AICPA Issues Papers and Practice Bulletins, and other pronouncements of the AICPA or FASB.

Generally Accepted Auditing Standards (GAAS): the auditing standards that are most widely recognized in the public accounting profession.

Health Care Financing Administration (HCFA): Agency within the U.S. Department of Health and Human Services (HHS) responsible for developing and implementing policies governing the Medicare and Medicaid programs.

Hold Day: a day for which the provider is paid to hold a bed open is counted as a resident day.

Hospital-affiliated facility: a facility that is a distinct part of a hospital provider, located either at the hospital site or within a reasonable proximity to the hospital.

Incremental Cost: the added cost incurred in alternative choices.

Independent Public Accountant: a Certified Public Accountant or Registered Public Accountant not employed by the provider.

Indirect Costs: costs which cannot be directly identified with a particular activity, service or product of the program. Indirect costs are apportioned among the program's services using a rational statistical basis.

Inflation Factor: a factor that takes into account the actual or projected rate of inflation or deflation as expressed in indicators such as the New England Consumer Price Index.

Interim Rate: a prospective Case-Mix rate paid to nursing facilities on a temporary basis.

Legend Drugs: drugs for which a physician's prescription is required by state or federal law.

Look-back: a review of a facility's actual costs for a previous period prescribed by the Division.

Medicaid Resident: a nursing home resident for whom the primary payor for room and board is the Medicaid program.

New England Consumer Price Index (NECPI-U): the New England consumer price index for all urban consumers as published by Standard & Poor's DRI.

OBRA 1987: the Omnibus Budget Reconciliation Act of 1987.

Occupancy Level: the number of paid days, including hold days, as a percentage of the licensed bed capacity.

Per Diem Cost: the cost for one day of resident care.

Prospective Case-Mix Reimbursement System: a method of paying health care providers rates that are established in advance. These rates take into account the fact that some residents are more costly to care for than others.

Provider Reimbursement Manual, HCFA-15: a manual published by the U.S. Department of Health and Human Services, Health Care Financing Administration, used by the Medicare Program to determine allowable costs.

Rate year: the State's fiscal year ending June 30.

Related organization or related party: an individual or entity that is directly or indirectly under common ownership or control or is related by family or other business association with the provider. Related organizations include but are not restricted to entities in which an individual who directly or indirectly receives or expects to receive compensation in any form is also an owner, partner, officer, director, key employee, or lender, with respect to the provider, or is related by family to such persons.

Resident Assessment Form: Vermont version of a federal form, which captures data on a resident's condition and which is used to predict the resource use level needed to care for the resident.

Resident Day: the care of one resident for one day of services. The day of admission is counted as one day of care, but the day of discharge or death is not. A paid hold day is counted as a resident day.

Restricted Funds and Revenue: funds and investment income earned from funds restricted for specific purposes by donors, excluding funds restricted or designated by an organization's governing body.

RUGS-III: A systematic classification of residents in nursing facilities based upon a broad study of nursing care time required by groups of residents exhibiting similar needs.

Secretary: the Secretary of the Agency of Human Services.

Standardized Resident Days: Base Year resident days multiplied by the facility's average Case-Mix score for the base year.

State nursing facilities: facilities owned and/or operated by the State of Vermont.

Swing-Bed: a hospital bed used to provide nursing facility services.

17 TRANSITIONAL PROVISIONS

17.1 Special Transitional Rates for Residents of the Vermont State Hospital Nursing Facilities

(a) For residents of Vermont State Hospital Nursing Facilities transferred into another Vermont licensed nursing facility (receiving facility) a special transitional per diem rate is available.

(b) The special transitional rate payable for each transferred resident shall consist of the current per diem rate for the receiving facility as calculated pursuant to Sections 5 to 9 of these rules and a supplemental incentive payment, to help defray the anticipated transitional expense of accommodating the needs of the transferred residents.

(1) Transferred residents shall be grouped into classes by the Department of Developmental and Mental Health Services in consultation with the Division of Licensing and Protection, based on the anticipated difficulty of and resources needed for the transition. The amount of the supplemental payment shall be based on the classification of the resident.

(2) The per diem supplemental payment shall be payable as a lump sum for up to

one year from the date of the transfer or to June 30, 1994, whichever period is the shorter, as long as the transferred person remains resident in the facility. Any advance payments for days during which the transferred person is not resident will be treated as overpayments and subject to refund by deductions from the provider's Medicaid payments.

(3) For transferred persons still resident in the receiving facility after June 30, 1994, the per diem supplemental payment will continue to be paid as long as the following criteria are satisfied:

(i) The transferred person continues to reside at the receiving facility.

(ii) The facility documents to the satisfaction of the Division of Licensing and Protection that the transferred resident continues to present significant behavior management problems by exhibiting behaviors that are significantly more challenging than those of the general nursing facility population.

(c) The transferred resident's current case-mix score in the Vermont State Hospital Nursing Facilities (as determined by the Division of Licensing and Protection before transfer) shall be assigned to the transferred resident for two quarters after the transfer and shall be used as the minimum score for that resident in the calculation of the facility's aggregate case-mix score. For subsequent quarters, the score shall be based on normal resident assessment procedures.

(d) To be eligible for a special transitional rate, the receiving facility must have in place a plan of care developed in conjunction with and approved by the Department of Developmental and Mental Health Services and the Division of Licensing and Protection.

17.2 **Special Rates for Medicaid Eligible Furloughees of the Department of Corrections**

A special rate equal to 110 percent of a nursing facility's ordinary Medicaid rate shall be paid for care provided to Medicaid eligible furloughees of the Department of Corrections.

17.3 **Quality Incentives**

Certain supplemental payments may be made to nursing facilities to be used for facility quality enhancements.

(a) Awards. Supplemental payments may be made to facilities that provide a superior quality of care in an efficient and effective manner. These payments will be based on:

(1) objective standards of quality, which may include resident satisfaction surveys, to be determined by the Department of Aging and Disabilities, and

(2) objective standards of cost efficiency determined by the Division.

(b) Innovative Pilot Projects. Supplemental payments may be made to facilities for all, or a portion, of the costs, approved by the Department of Aging and Disabilities, for creative and innovative pilot projects designed to improve and enhance residents' quality of life.

(1) In order to be eligible for supplemental payments under (b), the project must be suitable for replication in other facilities.

(2) Supplemental payments under (b) will not be available:

(i) to continue projects or programs already in place, or

(ii) to solve any issue of regulatory non-compliance.

(c) Supplemental Quality Incentive Payments.

(1) The supplemental payments may be made periodically from a quality incentive pool to certain nursing facilities whose operations meet the standards established pursuant to this subsection.

(2) Supplemental payments will not be available under this subsection for any facility that does not participate in the statewide resident satisfaction survey program, when implemented.

(3) Supplemental payments shall be expended by the provider to enhance the quality of care provided in the facility. In determining the nature of these expenditures, the provider shall consult with the facility's Resident Council.

(d) The method of distribution of the quality incentive payments shall be subject of a notice of practices and procedures issued pursuant to subsection 1.8(d) of these rules.

17.4 **Wage Supplement**

(a) Beginning with the state fiscal year 2000 until such time as all cost categories have been rebased on a base year no earlier than calendar year 2000, each facility shall receive a wage supplement paid from the net revenues appointed for the purpose by 33 V.S.A. §1956(b). The supplement shall be in addition to the total per diem rate as calculated pursuant to sections §§5-9, including the inflation factors in subsection §5.8. The wage supplement shall not be subject to the payment limits in subsections §§7.2(d), 7.3(d) and 7.4(d), but shall be subject to the aggregate upper payment limits in subsection §5.5(a).

(1) Each facility's annual wage supplement payment shall be calculated as the prorated share of the net revenues based on the ratio of its nursing wages, salaries and fringe benefits to the total of all nursing wages, salaries and fringe benefits paid by Vermont nursing homes participating in the Medicaid program, as reported on their 1997 Medicaid cost reports.

(2) The wage supplement payments shall be made in monthly installments.

(b) Wage Expenditure Reporting. Within 60 days after the end of each state fiscal year (or part thereof when applicable) during which wage supplement payments are made, each facility shall file on forms prescribed by the Division a report of the wages, salaries, fringe benefits, and bonuses paid to employees during the state fiscal year or part thereof. The filing shall include a calculation of the wage expenditure carryforward which is the difference between subparagraphs (1) and (2):

(1) the facility's expenditures on wages, salaries and fringe benefits, less Christmas bonuses (except for expenditures on wages, salaries, fringe benefits, and bonuses of owners and the administrator) in the baseline period, which shall be the last quarter of calendar year 1998. These expenditures shall be adjusted for accruals and annualized.

(2) the facility's expenditures during the State fiscal year (or part thereof) on wages, salaries and fringe benefits, less Christmas bonuses (except for expenditures on wages, salaries, fringe benefits, and bonuses of owners and the administrator), adjusted for accruals.

(3) Contract Workers. The wages, salaries, fringe benefits, and Christmas bonuses of contractual workers shall be treated as follows:

(i) If a facility incurs no costs for contract staffing in the baseline period in dietary, laundry, housekeeping, or therapies, at such time as the facility converts all staffing in any of these categories exclusively to contractual workers, the facility may remove the salaries of that category from the baseline period or prorated part thereof. No contractual salaries shall be included in the expenditures for the state fiscal year.

(ii) If a facility incurs contract costs for contract staffing in the baseline period in laundry, dietary, or housekeeping, the facility may include the wages, salaries, fringe benefits, less Christmas bonuses of such workers in both the baseline and subsequent state fiscal years as though they were employees of the facility, provided that the amount of the wages, salaries, fringe benefits, and Christmas bonuses of such contract workers can be fully documented for both periods. No amount may be included for any other contract costs, including but not limited to the costs of contractors' employees not actually working at the facility, overhead and profit.

(4) Wage expenditure reports shall be subject to the provisions of these rules relating to cost reports, except where such provisions are incompatible with the specific requirements of this subsection.

(c) Final Calculation of Total Wage Supplement. At such time as all cost categories are rebased on a base year no earlier than 2000, wage supplement payments shall cease. The total amount of each facility's wage supplement shall be the lesser of the cumulative total of the facility's annual wage expenditure carryforwards (but not less than zero) or the cumulative total of its wage supplement payments. In making this comparison wage supplement payments and the wage expenditure carry-forward for part of a fiscal year shall be calculated proportionately.

(d) Overpayment. To the extent that a facility's cumulative total of the facility's annual wage expenditure carryforward is lower than a facility's cumulative total of its wage supplement payments, the difference shall be deemed a Medicaid overpayment and shall be recouped pursuant to subsection §5.2(b)(7) to a maximum of the cumulative total of its wage supplement payments.

17.5 **Retroactive Payments to State Owned and Operated Nursing Facilities**

(a) Notwithstanding any other provision of these rules, for the period from May 1, 1999 though June 30, 2000, or such other later date as may be provided by statute, payment rates for state owned and operated nursing facilities shall be determined retrospectively by the Division based on the reasonable and necessary costs of providing those services.

(b) No less than 90 days before the beginning of the state fiscal year, a state owned and operate nursing facility shall file with the Division in a form acceptable to the Director, a proposed budget for that fiscal year. The Division shall review this filing for reasonableness and shall determine an approved budget which shall be the basis for the facility's interim rates for that fiscal year.

(c) After reviewing the facility's cost report, the Division shall set a final rate for the fiscal year based on the facility's allowable costs. The Division may limit allowable costs to those in the approved budget.

(d) At no time shall the final rates paid to State owned and operated nursing facilities exceed in aggregate the upper limits established in 42 C.F.R.

17.6 **Increased Indirect Category Limits for Special Hospital-Based Nursing Homes and Reduction in Inflation Factors for All Nursing Homes**

(a) Pursuant to the requirements of Act 62 of the 1999 legislative session and notwithstanding the requirements of subsection 7.4, the per diem limit on the base year indirect per diem rate for special hospital-based nursing facilities shall be 137 percent of the median calculated pursuant to subsection 7.4(c).

(b) The Division shall annually estimate the additional cost of the increase payments to the special hospital-based nursing facilities. These additional costs shall be deducted from the per diem rates of all nursing facilities, but the deduction shall not exceed the estimated total

amount of the annual inflation factors established pursuant to subsection 5.8.

(c) For the purposes of this subsection *special hospital-based nursing homes* shall be defined as those homes that meet the following criteria on June 2, 1999:

(1) are physically integrated as part of a hospital building with at least one common wall and a direct internal access between the hospital and the nursing home;

(2) are part of a single corporation that governs both the hospital and the nursing home; and

(3) file one Medicare cost report for both the hospital and the nursing home.

(d) This subsection shall remain in effect from July 1, 1999, though June 30, 2001.

17.7 **Application of Rule**

(a) Amended provisions of this rule shall apply to:

(1) all cost reports draft findings issued after the effective date of the most recent amendment, and

(b) all rates set after the effective date of the most recent amendment.

(b) With respect to any administrative proceeding pending on the effective date of the most recent amendment the Director or the Secretary may apply any provision of such prior rules where the failure to do so would work an injustice or substantial inconvenience.